U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 March 2006

CASE NO.: 2005-LHC-300

OWCP NO.: 08-124112

IN THE MATTER OF:

TOMMY FELTS

Claimant

v.

UMS/SEA-LAND

Employer

and

SIGNAL MUTUAL INDEMNITY ASSN., LTD

Carrier

APPEARANCES:

DENNIS L. BROWN, ESQ.

For The Claimant

MELANIE ROTHER, ESQ.
RICK L. RAMBO, ESQ.

For The Employer/Carrier

Before: LEE J. ROMERO, JR.
Administrative Law Judge

DECISION AND ORDER

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, et seq., (herein the Act), brought by Tommy Felts (Claimant) against UMS/Sea-

Land (Employer), and Signal Mutual Indemnity Association, Ltd. (Carrier).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. Pursuant thereto, Notice of Hearing was issued scheduling a formal hearing on August 17, 2005, in Houston, Texas. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. Claimant offered 26 exhibits, Employer/Carrier proffered 43 exhibits which were admitted into evidence along with one Joint Exhibit.[1] This decision is based upon a full consideration of the entire record.[2]

Post-hearing briefs were received from the Claimant and the Employer/Carrier. Based upon the stipulations of Counsel, the evidence introduced, my observations of the demeanor of the witnesses, and having considered the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

I. STIPULATIONS

At the commencement of the hearing, the parties stipulated (JX-1), and I find:

1. That an employer/employee relationship existed at the time of the alleged accident.

2. That the Employer was notified of the accident/injury on June 24, 2004.

3. That Employer/Carrier filed a Notice of Controversion on July 6, 2004.

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[1] At formal hearing, Claimant submitted a total of 25 exhibits and subsequently submitted one additional exhibit post-hearing. Employer did not object to the post-hearing submission; therefore, it was received into the record. At formal hearing, Claimant objected to Employer's Exhibits Nos. 14 and 21, which respectively consisted of Claimant's recorded statement and deposition transcript. Post-hearing, Claimant withdrew his objection to Employer's Exhibit No. 21, Claimant's deposition transcript. However, Claimant maintained his objection to Employer's Exhibit No. 14, contending the recorded statement has not been shown to be reliable as it was not taken under oath or transcribed by a certified court reporter, lacks the veracity required under the Federal Rules of Evidence, and contains words that were determined inaudible. As Employer/Carrier points out, however, the recorded statement was provided while in the presence of Claimant's counsel. After considering the foregoing, the recorded statement and deposition are admitted into the record to the extent the exhibits demonstrate inconsistencies in Claimant's testimony.

[2] References to the transcript and exhibits are as follows: Transcript: Tr.__; Claimant's Exhibits: CX-____; Employer/Carrier Exhibits: EX-____; and Joint Exhibit: JX-___.

4. That an informal conference before the District Director was held on August 17, 2004.

II. ISSUES

The unresolved issues presented by the parties are:

1. Causation, fact of injury.

2. Nature and extent of disability.

3. Whether Claimant has reached maximum medical improvement.

4. Entitlement to medical benefits.

5. Average weekly wage.

6. Attorney's fees, penalties and interest.

III. STATEMENT OF THE CASE

The Testimonial Evidence

Claimant

Claimant was 50 years old at the time of formal hearing and is a high school graduate.[3] He is a member of "ILA" Local 28, a "warehouse local" that does manual labor. (Tr. 31-32). He has worked as a longshoreman for fifteen years through ILA Local 28 and has always worked in maintenance and repair. Before he became a longshoreman, Claimant worked as a roughneck. (Tr. 33).

Claimant worked as a regular employee with Employer for approximately four years, doing maintenance and repair work (M&R).[4] His job duties primarily included repairing damaged containers and replacing wheel bearings, axles, and tires on chassis. (Tr. 34). He usually worked in the shop, as opposed to "in the lanes," but was sent on temporary assignments to the lanes. (Tr. 35-36). The "lane work" differed from shop work because it required a lot of bending and crawling. Additionally, while working in the lane, the employees had to "change everything out" so the chassis would pass DOT inspection; repairs that could not be made quickly were tagged "to the shop." (Tr. 36). Milton Randle was the walking foreman of the lanes. (Tr. 37).

[3] Claimant provided a recorded statement on July 13, 2004 and was deposed on December 21, 2004. (EX-14; EX-21).
[4] A "regular employee" works a steady, forty hour per week job. (Tr. 34).

During the week of June 21, 2004 through June 25, 2004, Claimant worked his regular job assignment as a shop M&R repairman.[5] Claimant testified that he was not limping at any time during the aforementioned week and that he did not experience "more than normal" back problems. On June 22, 2004, Claimant worked in the shop and did not see Mr. Randle. (Tr. 93-94).

Claimant testified that he had a couple of back surgeries in 1980 and strained his neck approximately one year prior to his alleged injury; however, none of the prior injuries caused problems on Monday, Tuesday, or early Wednesday of the week of June 21, 2004.[6] (Tr. 40).

After lunch on June 23, 2004, Claimant worked in the "lanes" from 1:00 p.m. to 3:30 p.m. He changed 22 tires, in addition to performing normal work such as climbing underneath the chassis. (Tr. 42, 44). Changing tires required the use of a 45 to 50-pound impact gun. Claimant testified that he would loosen the lug nuts and hit the cleat with a hammer, roll the tires off the chassis, mount new tires onto the chassis, and tighten the lug nuts. (Tr. 42-43). Each tire weighs 65 to 90 pounds. (Tr. 43).

When Claimant finished working at 3:30 p.m., he did not feel like he sustained an injury, but felt a little stiff and sore. (Tr. 44). He did not see Mr. Randle on June 23, 2004. He stated he was not limping on June 22, 2004 or June 23, 2004, and he did not tell Mr. Randle that he hurt himself at home. (Tr. 94). He testified that Mr. Randle and Mr. Sutton incorrectly stated that Claimant injured his back while at home. (Tr. 107-109). He did not tell anyone, including his supervisors, that he injured himself while away from work. (Tr. 107).

Claimant worked approximately 64.5 miles away from his home in Cleveland, Texas. He stayed at a motel for a few days each week due to the distance between his home and his workplace. He stayed at a motel on the night of June 23, 2004. (Tr. 45-46).

When Claimant awoke on June 24, 2004, he could not straighten his back for twenty to thirty minutes. (Tr. 44, 47). He went to work in the shop at 7:00 a.m. While at work, he crawled under a chassis using a roller and could not get up when he slid out from under the chassis. He told Charles Ross, David Harry, and Gary Sutton that he hurt his back at the lanes and could hardly move. He initially reported his injury to Mr. Sutton at approximately 10:00 a.m. (Tr. 48-49, 53). Mr. Sutton, the walking foreman at the shop, called Sterling Quaethem, his supervisor, to fill out an accident report. Claimant told Mr. Quaethem that he strained his back while changing tires and asked to see a doctor. (Tr. 49). Claimant believed he sustained a new back

[5] The walking foreman's records indicate Claimant worked in the lanes for 1.6 hours on June 21, 2004. (Tr. 103; EX-45, p. 49).
[6] Claimant was released to full duty work after all of his previous injuries. (Tr. 45).

injury while he was working in the lanes on June 23, 2004. The pain he experienced in the evening of June 23, 2004 and on the morning of June 24, 2004, was greater than the occasional low back pain he experienced due to his prior injuries. (Tr. 95).

Claimant was instructed to speak with Jim Hile, an insurance adjuster, before he could see a doctor. Claimant waited until 1:00 p.m. to speak with Mr. Hile and then informed Mr. Sutton and Mr. Hile's office that he was going to the emergency room.[7] (Tr. 50-52).

Claimant informed the emergency room doctors that he hurt his back at work and provided Mr. Hile's contact information. (Tr. 58-59). The emergency room physician examined Claimant, gave him a shot, and instructed him to see his family physician within the next few days. (Tr. 60). The instructions for "follow-up care" indicated Claimant could return to work on June 30, 2004. (Tr. 61). After he was released from the hospital or during the following day, Claimant called Employer's shop and told David Ward that he would be absent from work and was under a doctor's care. (Tr. 62-63).

Claimant filed an accident report that claimed he sustained a low back injury on June 23, 2004. However, his attorney originally filed a claim for compensation that identified an injury date of June 22, 2004 and his wife filled out emergency room forms that also identified the date of injury as June 22, 2004. According to Claimant, there was simply confusion as to the date of injury at the time his attorney and his wife filled out the paperwork. (Tr. 104-106).

On June 25, 2004, Claimant saw Dr. Williams, his family physician and told Dr. Williams that he strained his back while at work. Dr. Williams opined Claimant had bone spurs and referred Claimant to Dr. Kevin Moran, an orthopedic surgeon. (Tr. 64). On June 28, 2004, Claimant informed Dr. Moran that his injury was work-related. Dr. Moran ordered an MRI and x-rays and suggested Claimant treat with a chiropractor.[8] (Tr. 67). Claimant believed his work status was "no work." (Tr. 68).

Dr. Moran did not want to continue treating Claimant, so he sought treatment with Dr. Merrimon Baker.[9] On July 1, 2004, Claimant informed Dr. Baker that he injured his back while at work. Dr. Baker recommended a steroid injection and physical therapy and instructed Claimant to stay off work. Claimant testified that he was not able to have any of his medical care approved and paid for his medical treatment with his own money. (Tr. 70).

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[7] At his deposition, Claimant testified that he left the shop at noon on June 24, 2004. (EX-21, p. 7). At formal hearing, he indicated that he left work around lunchtime. He reviewed his phone records which clarified the actual time. (Tr. 98-99).

[8] Claimant did not receive the results of the MRI. (Tr. 141).

[9] Claimant previously treated with Dr. Baker over the course of several years due to various injuries. (Tr. 69).

During the last weeks of June and first weeks of July 2004, Claimant remained indoors most of the time and felt that he was getting better, though he was not at "a hundred percent." He used a medicine ball for exercise and stretching. (Tr. 72-73).

Claimant continued treating with Dr. Williams in July and August 2004 because the insurance adjuster would not allow him to see Dr. Baker. (Tr. 73). On direct examination, Claimant indicated that he learned the adjuster did not want him to see Dr. Baker when he provided a recorded statement to Mr. Hile. (Tr. 74). On cross-examination, Claimant testified that he did not know whether Mr. Hile specifically stated that he could not see Dr. Baker.[10] (Tr. 97).

As of July 15, 2004, Claimant was not physically able to return to work, but he was able to perform little tasks. (Tr. 75). On July 20, 2004, Employer requested that Claimant see Dr. Gary Freeman, who indicated steroids and physical therapy would help Claimant's problem. (Tr. 76-77). Employer/Carrier did not approve the suggested treatment and Claimant continued to exercise and care for himself on his own. (Tr. 78).

In August 2004, Claimant asked Dr. Williams to release him to return to work. Although Dr. Williams did not want to release him, he agreed to allow Claimant to return to work on September 3, 2004. (Tr. 79-80). On September 1, 2004, Claimant returned to work in Employer's shop and performed the same job duties as prior to his alleged injury without restrictions. He did not feel that he was 100% able to return to work, but he gradually increased his activities. (Tr. 81, 104). When he returned to work, Claimant was placed on a nightshift although he did not request the shift change. He requested to be moved back to a dayshift. (Tr. 82). He believed Employer made him work nights "to get back" at him for filing the instant claim. (Tr. 83).

On October 4, 2004, Dr. Kaldis examined Claimant at the request of the Department of Labor. Dr. Kaldis noted Claimant had "a little problem" and recommended medications and physical therapy.[11] (Tr. 83).

Claimant continued to work full-time with occasional back problems. (Tr. 84). He testified that the surveillance video from July 23, 2004 through July 29, 2004, showed him buying groceries and preparing to oversee his son install PVC pipe in a "camp trailer." His son never showed up with the materials and he did not actually perform any physical labor on that day. (Tr. 85). He further testified that the video showed him picking up trash that weighed

[10] Claimant's counsel indicated that Claimant's impression that he was not to see Dr. Baker stemmed from conversations between counsel and Claimant, rather than through actual statements made by Mr. Hile during the recorded statement. (Tr. 97-98).

[11] Claimant saw Dr. Kaldis again during the third week of November 2004. (Tr. 83-84).

approximately five pounds. He testified that the physical activities reflected in the surveillance video were not related to the physical activities he performs as an M&R repairman. (Tr. 86-87). A second surveillance video reflected Claimant's activities in the middle of September 2004, after he had returned to work. The video showed Claimant unloading pipe or scaffolding materials that weighed approximately 15 pounds.[12] (Tr. 87).

Due to his prior back surgery, Claimant had "good days and bad days," but he was "hurting bad" after June 23, 2004. (Tr. 109). In his recorded statement, Claimant stated that he sustained an injury on June 23, 2004, and that he was not having back problems beforehand. (Tr. 110; EX-14, pp. 12, 16). At formal hearing, he testified that, he would see Dr. Baker when his pain required medication during the five or six years prior to the alleged injury.[13] (Tr. 110). During his recorded statement,[14] Claimant indicated that he did not recall the last time he saw Dr. Baker and indicated that it had been "years." (EX-14, pp. 9-10). At formal hearing, Claimant testified that he believed he was being asked how long he has treated with Dr. Baker. (Tr. 113).

On cross-examination, Claimant agreed that he saw Dr. Baker for complaints of low back pain on six occasions in the year and one-half preceding his alleged 2004 injury. (Tr. 120). He testified that Dr. Baker incorrectly attributed his complaints of back pain to a January 23, 2003 accident, during two visits in July 2004.[15] (Tr. 120-122). He also agreed that Dr. Williams's records are "probably" correct that he presented with complaints related to a January 23, 2003 injury on January 23, 2003. He further agreed that he probably treated with Dr. Williams in December 2003 for complaints of back pain. (Tr. 124, 126). Claimant had no reason to disagree with a medical report that reflected he sought treatment for low back pain at the "Kingwood" emergency room and at Cleveland Regional Hospital on March 21, 2003. (Tr. 124-125).

Claimant testified that he only took medications "if [he] was hurting real bad." He did not take prescription medication on a daily basis, but would take medication a few times each week if he is

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[12] Claimant testified that a boy helped him load and unload most of the materials. (Tr. 87).

[13] In response to Interrogatory No. 9, which inquired about Claimant's hospitalizations prior to the alleged injury, Claimant responded that he saw Dr. Baker "approximately 7 or 8 years ago and he gave [Claimant] a steroid injection in [Claimant's] neck." The response was subject to further supplementation. (EX-13, p. 4). In response to Interrogatory No. 10, which inquired whether he had seen any doctors, for any reason, prior to the date of the alleged accident, Claimant referred to his response to Interrogatory No. 9 and identified Dr. Williams as his family doctor. (EX-13, p. 5).

[14] It is noted that Claimant was not under oath during the recorded statement.

[15] Claimant did not make an "on-the job injury claim" with Employer in January 2003 and he did not miss work from January 2003 through June 2004. (Tr. 148).

"hurting." Claimant testified that he filled the prescriptions for medication from Dr. Baker, but has "a drawer full of medications . . . that [he does not] take." (Tr. 128-130).

When Claimant told Mr. Hile, during his recorded statement, that he did not have back problems prior to June 23, 2004, Claimant meant he did not have back problems to the extent that he could not get up. (Tr. 127; EX-14, p. 16). At his deposition, Claimant indicated he could not return to work because he could not lift objects. (EX-21, p. 12). During formal hearing, he clarified that he was taken off work by his doctor and could not return to his job until he obtained a release. Although he could pick up items such as garbage bags, his job required him to lift items weighing from 16 to 90 pounds. Additionally, his job required pushing, pulling, and crawling. (Tr. 130-134). Claimant could bend while he was not working, but testified that it was painful. He stayed at home for one month following the alleged injury because normal living activities aggravated his condition. (Tr. 134-135).

At formal hearing, Claimant reviewed the surveillance video of record. He testified that he was able to bend on July 29, 2004, because he was on medication. (Tr. 135-136). Additional video footage showed Claimant lifting two by four pieces of plywood, which he testified weighed about two pounds. (Tr. 138-139).

In addition to his regular wages, Claimant also received a container royalty check and a vacation check each year. (Tr. 91). He received approximately $268 from a Welfare Fund after his injury. (Tr. 131).

Veronica Felts

Ms. Felts testified at formal hearing. On June 24, 2004, Claimant telephoned Ms. Felts around 12:00 p.m. and told her that he hurt his back. She did not notice that Claimant had back problems during the month or week before June 24, 2004. (Tr. 157). Claimant experienced ongoing back and neck problems for a number of years and saw doctors fairly frequently to obtain medication refills. (Tr. 158). In the days prior to June 24, 2004, Ms. Felts did not observe Claimant limping and she testified that he did not sustain an injury to his knee or back that caused him to limp. (Tr. 159). She did not see Claimant from June 20, 2004 until June 24, 2004. (Tr. 171). On the evening of June 23, 2004, Ms. Felts spoke with Claimant and he indicated that his back was hurting. Claimant told her that he had worked in the lanes and done a lot of heavy lifting. (Tr. 174-175).

When Ms. Felts arrived at Claimant's motel room on June 24, 2004, Claimant was "walking crooked" and needed her assistance to get into the car. He could not sit-up straight in the car. (Tr. 160). Claimant appeared to be in pain and was complaining. (Tr. 161). Ms. Felts informed the staff at Northeast Medical Center that Claimant injured himself on the job. (Tr. 161-162). She provided Mr. Hile's

telephone number, but ultimately provided Claimant's "regular health insurance card" to obtain medical treatment. (Tr. 162).

Ms. Felts drove Claimant to an appointment with Dr. Williams and informed Dr. Williams that Claimant injured himself while working in the lanes. She made it clear that Claimant sustained an on-the-job injury. (Tr. 164). She also drove Claimant to an appointment at Dr. Moran's office because Claimant could not drive. (Tr. 164).

During the last few weeks of June and the first few weeks of July 2004, Claimant did not do anything; Ms. Felts testified Claimant would move from his bed to the couch and she had to motivate him to move around. (Tr. 166-167). Towards the middle and later parts of July 2004, Claimant would walk around the yard or "piddle around" in his camper. Her son performed any heavier work around the house. (Tr. 167). By the end of July 2004, Claimant was exercising at home. (Tr. 168). Based on their financial situation, Claimant and Ms. Felts decided that he should ask Dr. Williams to release him to return to work in August 2004. (Tr. 169).

Milton J. Randle

Mr. Randle testified at formal hearing and was deposed by the parties on July 29, 2005. (CX-24). He is employed by Employer and is a member of the "ILA 28" union. In June 2004, Mr. Randle was employed as a walking foreman and was also a crane operator. (Tr. 180). On a daily basis, workers in the lanes repair and change tires and make sure the chassis are road worthy before leaving Employer's facility. (Tr. 182).

Employer's procedure for reporting an injury required an employee to immediately inform the walking foreman or assistant foreman of the injury. The foreman "writes it up" to have a record of the accident. If the injury is reported on the day after it occured, the employee is instructed to contact Mr. Hile. (Tr. 184).

Mr. Randle learned of Claimant's injury when he was operating a crane. Mr. Randle's supervisor asked if someone had been hurt. Later in the day, his supervisor asked if Claimant had injured himself and Mr. Randle responded that he had not been told of an injury. (Tr. 181; CX-24, p. 32). During their conversation, Mr. Randle provided the information that was included in his typed statement. (CX-24, p. 32).

According to Mr. Randle's typed statement, Mr. Randle inquired why Claimant was limping and Claimant responded that he hurt himself "at the house." (Tr. 189; CX-24, pp. 34, 45). Mr. Randle jokingly stated that he would shoot Claimant if the injury occurred on the job. (Tr. 189, 191; CX-24, p. 46). He was not attempting to discourage

Claimant from reporting an injury.[16] (Tr. 192). At his deposition, Mr. Randle testified that Claimant was "slightly limping" and was not holding his back. Claimant did not state that he was limping because his back hurt. (Tr. 198; CX-24, pp. 44, 46).

Mr. Randle did not type his statement, but testified that it accurately reflected the statement he provided in the present case. (Tr. 188). The conversation referenced in the typed statement occurred before the alleged injury; however, Mr. Randle could not recall the date on which the conversation occurred.[17] (Tr. 188, 190). Mr. Randle did not the change the date on his recorded statement from June 29, 2004 to June 22, 2004, and his initials are not next to the change.[18] He did not request the date change and was told of the change at a safety meeting. (Tr. 195; CX-24, pp. 39-40).

Mr. Randle testified that Claimant indicated he was having problems prior to the week of June 21, 2004. He testified that the problems did not concern his ability to work, but Claimant mentioned a need to "get away" due to "the situation on the job." (Tr. 192-193; CX-24, p. 75).

When Mr. Randle was first hired by Employer, he worked in the shop. (CX-24, p. 20). Although he testified that shop work may require a little more "repair," he indicated there is no difference between working in the shop and in the lanes because both involve repair of boxes and chassis. In the lanes, the employees make minor repairs, such as repairing lights, changing tires, welding a cut or crack, or stabilizing "the boilers." (CX-24, p. 21). The job required crawling under the chassis to make the inspections and repairs. (CX-24, p. 22).

Mr. Randle testified that changing tires was not very physical work, although he indicated it required use of a "one-inch impact" that weighed approximately 20 pounds. (CX-24, p. 22). Employees were generally not to lift more than 50 pounds while working in the inspection lanes. (CX-24, p. 62). He testified that tire changing required a "technique." (CX-24, p. 22). The work pace in the lanes was "modest," although the work was steady on most days with some down time. (CX-24, pp. 24-25).

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[16] Employer has an incentive program to encourage job safety which awards a dinner to the entire terminal if it was accident-free for three months. At the end of the year, Employer has a drawing for a big prize and every employee who was accident-free for the entire year has his name placed in the drawing. (CX-24, p. 13).

[17] At his deposition, Mr. Randle testified that he saw Claimant limping one day before he spoke with Mr. Quaethem about the alleged injury. (CX-24, p. 44).

[18] At his deposition, Mr. Randle could not recall whether the date was changed before or after he signed the statement. (CX-24, p. 39). At formal hearing, he testified that the date was changed after he signed the statement. (Tr. 195).

Claimant was not one of Mr. Randle's regular workers because he usually worked in the shop. (Tr. 181; CX-24, p. 25). Mr. Randle felt Claimant was a good worker and did not notice that Claimant had any physical problems prior to the alleged June 2004 incident. He had no recollection of Claimant holding his back or being a slow worker. Prior to the alleged incident, Claimant never told Mr. Randle that the work was aggravating his back. (CX-24, p. 29). Claimant did not complain about any pain in his leg or back and he worked without any problems. (CX-24, p. 49).

An employee is moved from the dayshift to the nightshift when the employee requests such a change. (Tr. 182). An employee would not be moved to the nightshift because he had been injured on the job or was out of work for one or two months. (Tr. 183).

Gary Sutton

Mr. Sutton, a shop foreman for Employer, was deposed by the parties on August 11, 2005. (CX-23, p. 10). He has been a member of "ILA local 28" for six or seven years. (CX-23, p. 12). The shop workers repair containers and chassis. The work is physical labor that requires bending, stooping, lifting, and crawling. (CX-23, p. 18).

Mr. Sutton would send shop workers to help in the lanes. (CX-23, p. 21). The employee's pay remained the same regardless of where he worked. Mr. Sutton did not know whether the shop timekeeper accounted differently for time worked in the lanes. (CX-23, pp. 23-24). While working in the lanes, the employees inspected equipment and changed tires to make sure trucks were road safe. (CX-23, p. 27).

In June 2004, Mr. Sutton was Claimant's supervisor. (CX-23, pp. 12-13). Claimant was a good worker and Mr. Sutton never had to fire him, formally reprimand him, or file complaints with Employer or the union regarding his work or attitude. (CX-23, p. 15). He has known Claimant for approximately seven years and met him outside of work. He and Claimant both live in Cleveland, Texas, and have carpooled to work together. (CX-23, pp. 28, 31). Mr. Sutton would have noticed if Claimant had difficulty performing his job due to a back or leg injury.[19] (CX-23, p. 25). He would not have known whether Claimant was limping while working in the inspection lanes. (CX-23, p. 64).

On June 24, 2004, Claimant performed his normal work in the shop from 7:00 a.m. until 10:00 a.m. At 10:00 a.m., Charles Ross told Mr. Sutton that Claimant's back was hurting. When he saw Claimant, Claimant stated, "I twisted or turned wrong or something last night or something. I don't know what I did, but my back is killing me." Mr. Sutton brought Claimant to Mr. Quaethem, who filled out the paperwork.

[19] If he noticed an employee showing evidence of an injury, Mr. Sutton would speak to the employee to learn about his condition. (CX-23, p. 26).

(CX-23, pp. 34-35). Mr. Sutton testified that Claimant appeared to be in pain. (CX-23, p. 35).

Mr. Sutton recalled providing a statement regarding Claimant's report of the alleged injury.[20] The statement indicated that Claimant reported back pain at 10:00 a.m., that Mr. Quaethem filled out reports, and that Claimant waited in the break room until 12:00 p.m. (CX-23, p. 38).

Employer's policy required an injured employee to immediately notify the foreman or immediate supervisor of the injury and fill out appropriate paperwork. If the injury required treatment, the employee could go to the clinic. (CX-23, p. 36).

At the time of the deposition, Claimant had returned to work for Employer and was performing the job he held prior to the alleged injury. Mr. Sutton testified that Claimant's foreman on the night shift told him that Claimant requested to work nights when he returned to work. (CX-23, pp. 51, 62). An employee would be moved to a different shift only if the employee requested a shift change. (EX-23, p. 55).

The Medical Evidence

Dr. Merrimon Baker[21]

On May 23, 1995, Claimant presented to Dr. Baker with complaints of a low back injury and pain radiating into his left leg and groin. Claimant reported that he injured his low back while lifting heavy tires. An x-ray revealed a "pars defect" at the "L5" level, but did not show spondylolisthesis. Dr. Baker diagnosed "[a]cute pars defect at L5" and "[l]eft leg sciatica." (EX-37, p. 130). On May 30, 1995, Claimant underwent a bone scan with an emphasis on his lumbar spine, which returned normal results. (EX-36, p. 11). Claimant attended monthly follow-up visits from June 1995 to February 1996 and attended physical therapy in August 1995.[22] (EX-37, pp. 121-129, 159).

A lumbar MRI dated July 21, 1995, showed "minimal right epidural fibrosis at L5-S1 surrounding the right S1 nerve root" and "a small

[20] He could not recall when he provided the statement, but knew that it was not given on the date Claimant reported the injury. (CX-23, p. 39). Mr. Hile asked Mr. Sutton to give the statement. (CX-23, p. 40).

[21] Dr. Baker's credentials are not identified in the record.

[22] Additionally, Claimant was examined by Dr. Dan W. Parkinson on August 13, 1995 and December 5, 1995, at the request of Claimant's employer. Dr. Parkinson initially diagnosed a "lumbosacral sprain and strain with intermittent left lower extremity radiation" and noted that a "small contained L1-L2 disc herniation with no nerve root impingement" was identified on an MRI. On December 5, 1995, Claimant continued to present with intermittent radicular symptoms and complaints regarding his lower lumbar spine. Dr. Parkinson opined Claimant's condition was "resolving." (EX-37, pp. 146, 149-150).

herniation at L1-L2" that did not "appear to directly contact either the L1 or the L2 nerve roots." (EX-37, pp. 189-190). On July 25, 1995, Dr. Baker noted than a MRI showed no recurrent disc herniation. On November 28, 1995, he assigned a 26% disability rating to Claimant. (EX-37, pp. 123, 127). On May 7, 1996, Claimant presented with "bilateral chronic S1 radiculopathy." He continued to complain of severe lower back pain on November 7, 1996.[23] (EX-37, pp. 120-121).

In December 1997, Claimant presented with injuries to his left shoulder and left knee sustained in a motor vehicle accident. (EX-37, p. 119).

On February 16, 2000, Claimant reported sustaining an injury to his cervical spine while pushing an 18-wheeler tire on February 15, 2000. Dr. Baker diagnosed cervical radiculopathy and performed a series of cervical epidural steroid injections during February and March 2000.[24] (EX-37, pp. 110-111, 113-114). On March 7, 2000, Dr. Baker indicated an MRI showed a disc herniation at Claimant's "C5-6" level. (EX-37, pp. 111, 141). Claimant continued to present with complaints of neck pain in April, August, and November 2000 and in February 2001. (EX-37, pp. 100, 104-109). In March, May, and June 2001, Claimant underwent more cervical epidural steroid injections due to his persistent complaints of pain.[25] (EX-37, pp. 94-99, 115-116). On October 18, 2001, he reported more good days than bad days. (EX-37, p. 71).

On June 28, 2002, Claimant presented with "bilateral elbow pain" and neck pain after involvement in a motor vehicle accident. Dr. Baker diagnosed a cervical strain, "bilateral cubital tunnel syndrome," and "bilateral lateral epicondylitis." (EX-37, p. 88). In December 2002, Dr. Baker noted improvement in Claimant's condition. (EX-37, pp. 84, 86). On April 22, 2003, however, Dr. Baker found no significant change in Claimant's neck condition and indicated Claimant continued to experience pain in his elbows. He instructed Claimant to avoid heavy lifting, as well as bending and stooping. (EX-37, p. 81).

On January 28, 2003, Claimant reported experiencing an immediate onset of low back pain after lifting heavy items at work. Dr. Baker identified the injury as a "new injury" and diagnosed a lumbar strain. He instructed Claimant to avoid heavy lifting, bending, and stooping. (EX-37, pp. 68-69). At a follow-up visit on September 16, 2003,

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[23] On April 19, 1996, Dr. Norma S. Mendoza opined Claimant suffered from "[f]ailed back syndrome." (EX-37, pp. 143-144).

[24] A February 24, 2000 nerve conduction velocity study of Claimant's upper extremities returned normal results. (EX-37, pp. 136-137).

[25] On March 20, 2001, Claimant underwent a cervical myelogram and a post-myelogram CT of his cervical spine. The myelogram showed epidural defects at his C5-6, C6-7, and C4-5 levels. The post-myelogram CT showed left-sided facet arthropathy at Claimant's C2-3 level, as well as 2.0 mm to 3.0 mm protrusions at the C3-4 and C4-5 levels. A "diffuse bulge" was noted at the C5-6 level. (EX-37, p. 184).

Claimant continued to complain of low back pain, which he described as "aching, throbbing, sharp, tender, burning, miserable, and unbearable." Dr. Baker maintained the diagnosis of a lumbar strain and allowed Claimant to work without restrictions. (EX-37, p. 67).

On December 4, 2003, Claimant worked full duty, but reported significant low back pain with heavy lifting, bending, or stooping. Dr. Baker found "significant paraspinal spasms in the lower lumbar region" and Claimant was allowed to continue working without restrictions. (EX-37, p. 66). On January 22, 2004, Claimant reported increased tenderness in his lumbar spine with increased activity and cold weather. Dr. Baker diagnosed a lumbar strain. (EX-37, p. 65). On April 1, 2004, Claimant complained of increased pain and Dr. Baker diagnosed lumbar sciatica. (EX-37, p. 63). Dr. Baker continued to release him to work without restrictions and prescribed Soma, Lortab, Prednisone, and Zanaflex. (EX-37, p. 63, 65).

On May 20, 2004, Claimant presented with complaints of minimal pain in his lumbar spine and increased pain in his cervical spine, which was exacerbated by use of a 10 to 12-pound hammer while at work.[26] His physical examination revealed continued tenderness in his lower lumbar spine with limited range of motion. Dr. Baker reviewed a lumbar MRI dated April 9, 2004. (EX-37, p. 61). The MRI showed "[s]mall, broad based disc bulges with evidence of posterior annular tears" at Claimant's L3-L4, L4-L5, and L5-S1 levels. It revealed "moderately compromised" neural foramina and "[a]ssociated moderate facet hypertrophic changes." The MRI further revealed "[d]isc dessication, small osteophytes, and moderate facet hypertrophic changes," as well as decompressed spinal canal and neural foramina at the two upper lumbar levels. (EX-37, pp. 61, 77-78). Dr. Baker diagnosed "lumbar HNP" and "cervical strain" and suggested that Claimant would "benefit from facet blocks at L3-L4, L4-L5, and L5-S1 due to his continued and ongoing lumbar spine pain and spasm." He refilled Claimant's prescriptions of Soma, Lortab, Prednisone, and Zanaflex. (EX-37, p. 62).

On July 1, 2004, Dr. Baker identified the date of injury as January 23, 2004.[27] (EX-37, p. 59). On July 1, 2004, Claimant reported that he "exacerbated his low back while on the job working on 'the line.'" Physical examination revealed "lower lumbar spine pain with radiation down into the right leg." Dr. Baker noted Claimant was unable to sit straight and exhibited right groin pain. He diagnosed "lumbar HNP" and "cervical strain." (EX-37, pp. 59-60). On July 15, 2004, Dr. Baker again identified the date of accident as January 23, 2004. Claimant's physical exam was essentially unchanged and Dr. Baker maintained his previous diagnoses of "lumbar HNP" and a cervical

[26] Dr. Baker's medical records from January 28, 2003 through May 20, 2004 identify the date of injury as January 23, 2003. (EX-37, pp. 61, 63, 65-69).
[27] Insurance forms referencing treatment on July 1, 2004 and July 15, 2004, reflect the date of injury as June 23, 2004. (EX-37, pp. 55-56).

strain.[28] Dr. Baker prescribed Bextra and a Medrol Dose Pack and refilled Claimant's prescriptions of Lortab and Soma. (EX-37, pp. 57-58).

On October 17, 2005, Dr. Baker generated an additional report in which he stated that he treated Claimant in 2004 for back and neck complaints arising from a January 23, 2003 incident. He noted his records indicated that Claimant's complaints increased significantly at the July 1, 2004 examination. He further noted that Claimant had not previously presented with pain radiating into his right leg nor had Claimant previously presented with groin pain. Dr. Baker stated that the July 1, 2004 and July 15, 2004 reports should have identified a new injury due to the "exacerbating incident on the line." (CX-29).

Cleveland Regional Medical Center (CRMC)

On June 5, 1995, Claimant presented with complaints of low back pain and pain in his lower left extremity after injuring his back while lifting heavy tires. (EX-36, p. 15). Claimant received lumbar epidural steroid injections into his "L2-3" level on June 5, 1995 and July 7, 1995, and he received a lumbar epidural steroid injection into his "L3-4" level on June 30, 1995. (EX-36, pp. 19, 30, 39). Claimant's activities were restricted to no overhead lifting and no lifting of greater than 20 pounds. (EX-36, pp. 21, 37). He underwent physical therapy for his back pain from July 31, 1995 to August 25, 1995, but continued to complain of low back and mid-back pain. (EX-36, pp. 47-54).

From August 19, 1997 to August 22, 1997, Claimant was treated for post-traumatic effusion of his left elbow. (EX-36, pp. 58-103).

On October 24, 1997, Claimant was admitted to the CRMC emergency room after he was involved in a motor vehicle accident. He presented with complaints of neck pain and stiffness, a headache, left hip pain, and left knee pain. (EX-36, pp. 105, 112-113). X-rays of his cervical spine and left shoulder returned normal results and Claimant was diagnosed with a cervical strain and left shoulder contusion. (EX-36, pp. 105, 110).

On October 20, 1998, January 1, 1999, and May 10, 2001, Claimant presented with complaints of severe headaches. (EX-36, pp. 117-123, 130-138, 143-145). On July 12, 2001, he presented to the emergency room with a swollen right elbow and severe rash; he was diagnosed with poison ivy. (EX-36, pp. 155-163). From May 11, 2002 to May 12, 2002, Claimant presented with an abscess on his left arm that was diagnosed as a cutaneous abscess. (EX-36, pp. 169, 171, 184-194). On May 13, 2002, he returned to the emergency room with swelling and redness and

[28] Several of Dr. Baker's prior medical reports specified that Claimant could either return to work at full duty or without restrictions or listed certain work restrictions. The medical reports of July 2004 do not indicate Claimant's work status.

a spider bite wound was noted in his left forearm.[29] (EX-36, pp. 200-205).

On June 28, 2002, Claimant was admitted to the CRMC emergency room following a motor vehicle accident. He presented with complaints of pain in his back, neck, and left hip, as well as pain extending from his left shoulder to his elbow. (EX-36, pp. 211, 213). The diagnosis of his condition included a cervical strain.[30] (EX-36, p. 214). X-rays of Claimant's cervical spine, left shoulder, and left hip were unremarkable. (EX-36, pp. 217-219).

On March 21, 2003, Claimant presented with complaints of sharp, burning, and aching pain in his low back following an injury at work on March 20, 2003. Claimant indicated he pulled and twisted his back while turning and bending. The diagnosis was an acute myofascial lumbar strain. (EX-36, pp. 225-228).

Northeast Medical Center Hospital

On May 13, 2001, Claimant presented with complaints of a headache for one week. He reported a history of experiencing monthly headaches for 5 to 10 years. He was diagnosed with a migraine headache.[31] (CX-16, pp. 16-17; EX-33, pp. 13-14).

On June 24, 2004, Claimant complained of stabbing pain in his lower back after injuring his back at work.[32] (CX-16, pp. 5, 9; EX-33, p. 32). The medical report indicated that the pain was caused by a recent injury, but also noted a history of a prior back injury and prior chronic back pain. (CX-16, p. 6; EX-33, p. 33). The "clinical impression" included "acute myofasical strain" of Claimant's lumbar area, as well as acute and chronic low back pain. (CX-16, p. 7; EX-33, p. 34). The instructions for follow-up care indicated Claimant could return to work on June 30, 2004. (EX-33, p. 38).

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[29] On May 13, 2002, Claimant presented with inflammation and blistering of his left elbow, as well as right knee inflammation. Dr. Fredrick Hill diagnosed "cellulitis of the left forearm secondary to methicillin-resistant Staphylococcus aureus." He was discharged on May 20, 2002. (EX-35, pp. 26-128). Dr. Hill's medical records further indicate that Claimant underwent a CT scan of his "paranasal sinuses" on May 18, 2002, which "fail[ed] to demonstrate significant paranasal sinus abnormality . . . ." (EX-27, p. 11). On May 22, 2002, Dr. Hill treated Claimant for a spider bite and noted Claimant had full range of motion of the joints in his hand. (EX-27, p. 10).

[30] The remainder of the diagnosis is illegible, although it appears to suggest mild left "AC" separation and shoulder contusion. (EX-36, p. 214).

[31] On May 13, 2001, Claimant also was admitted to the emergency room of Methodist Hospital in Houston, Texas, with complaints of an acute headache, which had lasted for approximately five days. (EX-32, pp. 9-11). A CT scan of Claimant's brain returned normal results. (EX-32, p. 20). On May 15, 2001, Claimant returned with continued complaints of a headache. (EX-32, p. 25).

[32] According to the Patient Information Data Form, Claimant's back pain began on June 22, 2004. (CX-16, p. 9; EX-32, p. 36).

Balmore W. Williams, M.D.[33]

On January 23, 2003, Claimant presented to Dr. Williams with complaints of back pain after pulling a muscle in his back. Dr. Williams diagnosed low back pain. (EX-34, pp. 9-10). On February 12, 2003, Claimant complained of migraine headaches. (EX-34, p. 11). On March 17, 2003 and April 3, 2003, Claimant presented with complaints of elbow pain. (EX-34, p. 13). On April 21, 2003, Claimant requested nerve medication and complained of a persistent sore throat. (EX-34, p. 14).

On December 1, 2003, Claimant presented with complaints of lower back pain and Dr. Williams noted he engaged in heavy lifting at work. (EX-34, p. 20). On March 18, 2004, Claimant returned to Dr. Williams for a "BP checkup" and he reported no change in his back pain on March 31, 2004. (EX-34, pp. 21-22).

On June 25, 2004, Claimant presented with complaints of low back pain. He indicated that he sustained an injury at work, sought emergency room treatment, and was instructed to follow-up with his family doctor. (CX-11, p. 3; EX-34, p. 23). X-rays of his lumbar spine revealed "hypertrophic spurring of the lumbar vertebral bodies." (CX-11, p. 4; EX-36, p. 287). On August 18, 2004 and August 31, 2004, Claimant's complaints included back pain. (EX-34, pp. 17-18). An undated work release form released Claimant to return to work on September 3, 2004.[34] (CX-11, p. 1).

On September 21, 2004, Dr. Williams indicated Claimant's low back pain was secondary to a work-related incident[35] and noted Claimant returned to work because he needed money. He diagnosed chronic back pain. (EX-34, p. 26). On October 14, 2004, Dr. Williams opined Claimant's low back pain was secondary to "hypertrophic spurring of lumbar vertebral bodies." Dr. Williams indicated that Claimant's condition was not improving without medication. (EX-34, p. 27). Claimant continued to complain of low back pain in November and December 2004 and Dr. Williams continued to diagnose his condition as chronic back pain. (EX-34, pp. 28-30).

Kingwood Medical Center Hospital (Kingwood)

On March 21, 2003, Claimant presented with complaints of moderate low back pain with radiation into his leg, which was caused by a "recent injury" described as a "near-fall." The medical record indicated that Claimant re-injured himself on "3/20" and noted five previous back surgeries. (EX-35, pp. 16, 18-19). The "clinical impression" was identified as "acute myofasical strain." (EX-35, p.

[33] The record does not identify the credentials of Dr. Williams.
[34] A prescription note dated August 31, 2004, indicated Claimant would be able to resume normal activities on September 6, 2004. (EX-34, p. 42).
[35] Dr. Williams did not reference a date of the work-related incident.

17). X-rays of Claimant's lumbar spine, dated March 21, 2003, showed "mild disc degenerative changes at L1-2 and L2-3" and "probably spondylolysis of L5, but no evidence of spondylolisthesis." (EX-35, p. 20).

Kevin M. Moran, M.S., M.D.[36]

On June 28, 2004, Dr. Moran examined Claimant through referral by Dr. Williams. Claimant presented with complaints of low back pain and right lower extremity pain after injuring his back while at work. Dr. Moran noted that "outside films" showed a spondylolysis at "L4/5." His impression consisted of "[r]epeat herniated disc vs. exacerbation of spondylolysis" and he recommended an MRI. (CX-15, p. 2; EX-30, p. 12). Claimant was taken off work. (CX-15, p. 1).

Gary C. Freeman, M.D.[37]

On July 20, 2004, Dr. Freeman examined Claimant at Employer's request. Claimant indicated that he suffered significant low back pain and right leg pain after working hard on June 23, 2004. (CX-13, p. 4; EX-28, p. 12). At the time of his examination, Claimant reported an improvement, but complained of pain in his low back and into his right leg and foot. Dr. Freeman reviewed an MRI obtained by Dr. Baker and found no herniation or significant stenosis. Physical examination revealed "some flattening of the lumbar lordotic curve" and approximately a 20% decrease in Claimant's low back range of motion. (CX-13, p. 5; EX-28, p. 13).

Dr. Freeman opined Claimant sustained "a low back strain and sprain associated with previous surgery and the resultant scarring." He recommended treatment with steroids and therapy. He further opined Claimant could not perform his regular work activities, but indicated that the prognosis regarding recovery was good. (CX-13, p. 5; EX-28, p. 13).

On September 28, 2004, Dr. Freeman reviewed surveillance video of Claimant dated July 27-29, 2004. He found an "obvious lack of dysfunction or discomfort" in Claimant's activities and opined Claimant had reached maximum medical improvement, with no impairment, as of the date of the video. (CX-13, p. 1; EX-28, p. 15).

Michael G. Kaldis, M.D.

On October 13, 2004, Claimant was examined by Dr. Kaldis at the request of the Department of Labor.[38] Claimant presented with complaints of low back pain and right leg pain resulting from twisting and lifting twenty-two 18-wheeler tires while at work. Claimant complained of increased pain with lifting, bending, and sitting. Dr.

[36] Dr. Moran is board-certified in orthopaedic surgery. (CX-15, p. 1).
[37] Dr. Freeman is board-certified in orthopaedic surgery. (CX-13, p.6).
[38] The record does not identify the credentials of Dr. Kaldis.

Kaldis noted Claimant had previously undergone a laminectomy, two surgeries at the L3-4 level, and three "injections." (CX-12, p. 7; EX-29, p. 10). He found "significant tenderness over the paraspinous region of the lumbar spine." He noted Claimant had returned to work for monetary reasons and continued to work with lower back pain. (CX-12, p. 9; EX-29, p. 12).

On October 18, 2004, Dr. Kaldis issued a follow-up report after reviewing additional records. He noted that an MRI scan revealed evidence of disc protrusion at Claimant's L3-L4 level. In addition, he reviewed reports by Dr. Moran, Dr. Williams, and Dr. Freeman. Dr. Kaldis opined Claimant injured himself while working on June 23, 2004 and diagnosed chronic low back pain and lumbar radiculitis. He suggested there existed a "direct relationship" from Claimant's injury to the low back pain and opined Claimant had not reached maximum medical improvement. Dr. Kaldis recommended physical therapy and medication. (CX-12, p. 5; EX-29, p. 19).

On November 23, 2004, Claimant continued to complain of chronic intermittent back pain, occasionally radiating into his leg. Dr. Kaldis noted Claimant worked full duty without restrictions and with no problems. (CX-12, p. 3; EX-29, p. 23).

On November 29, 2004, Dr. Kaldis reviewed surveillance video of Claimant dated September 15-16, 2004, July 23, 2004, and July 27-29, 2004. According to Dr. Kaldis, Claimant did not exhibit restricted motion on bending, nor did he exhibit signs of restriction of his back or signs of back pain. Dr. Kaldis found no permanent impairment as a result of Claimant's workers' compensation claim regarding his back. (CX-12, p. 2; EX-29, p. 22). His handwritten notation on the report indicated that Claimant was "at MMI on this date retrospectively." In response to "Direct Questions," Dr. Kaldis opined Claimant had reached maximum medical improvement as of July 28, 2004. (EX-29, pp. 24B-24C).

The Vocational Evidence

Surveillance Video

On July 28, 2004, Claimant was filmed while walking around and standing in a camper trailer from approximately 10:41 a.m. until 11:20 a.m. The surveillance video showed Claimant bending at the waist and carrying long pieces of wood into the camper trailer. Claimant was wearing a toolbelt. The nature of his activities while in the camper trailer is unclear from the video. On July 29, 2004, surveillance video showed Claimant climbing into the bed of a pick-up truck and repeatedly bending at the waist to pick up garbage. Claimant lifted a garbage can and emptied it into a large trash bin. He climbed out of the bed of the pick-up truck using the truck's sidestep.[39] (EX-25).

[39] Additional surveillance video dated July 23, 2004 and July 27, 2004, showed Claimant walking or driving. (EX-25).

On September 15, 2004, Claimant was filmed working on a vehicle in a shop from approximately 10:35 a.m. until 10:59 a.m. The vehicle was raised and Claimant performed overhead work. Claimant was shown bending at the waist, leaning slightly backwards while working overhead, and lifting a tire. The video also showed Claimant removing a gun case from his vehicle at approximately 12:12 p.m. and bending at the waist and squatting to remove a rifle or shotgun from the case. On September 16, 2004, Claimant was filmed bending at the waist and carrying/moving plywood. The footage also showed Claimant lifting large frames or pieces of scaffolding alone and with assistance. (EX-26).

The Contentions of the Parties

Claimant contends he presented a **prima facie** case that he was temporarily totally disabled from June 24, 2004 through September 1, 2004. He further contends the medical reports of record establish that his injury required medical care and that Employer unreasonably denied authorization for such medical care. Claimant also argues that Employer violated Section 48(a) of the Act by withholding benefits and assigning Claimant to the afternoon shift upon his return to work.[40]

Employer challenges the credibility of Claimant's testimony and argues his claim has no merit due to Claimant's lack of credibility. Employer contends Claimant did not sustain a work-related injury on June 23, 2004, and, thus, is not entitled to any compensation or medical benefits. In the alternative, Employer further contends Claimant reached maximum medical improvement by July 28, 2004, and should not be entitled to any compensation thereafter. Employer also contends Claimant earned an average weekly wage of $1,191.49.

Employer contends the claim of a Section 48(a) violation should be summarily denied because Claimant did not raise the issue before the district director or at formal hearing. Employer further contends the record does not support Claimant's allegation that Employer placed him on the nightshift as punishment for filing the instant claim.

IV. DISCUSSION

It has been consistently held that the Act must be construed liberally in favor of the Claimant. Voris v. Eikel, 346 U.S. 328, 333 (1953); J. B. Vozzolo, Inc. v. Britton, 377 F.2d 144 (D.C. Cir. 1967). However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the

[40] Claimant and Employer referred to Section 49 in their post-hearing briefs. Prior to the 1984 amendments, Section 48(a) of the Act was numbered "49." Occasionally, it is still, though incorrectly, referred to as "Section 49." For this Decision and Order, "Section 48(a)" will be used in place of the parties references to "Section 49."

Claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. Director, OWCP v. Greenwich Collieries, 512 U.S. 267, 114 S.Ct. 2251 (1994), aff'g. 990 F.2d 730 (3rd Cir. 1993).

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. Duhagon v. Metropolitan Stevedore Company, 31 BRBS 98, 101 (1997); Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce, 551 F.2d 898, 900 (5th Cir. 1981); Bank v. Chicago Grain Trimmers Association, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968).

A. The Compensable Injury

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of or in the course of employment." 33 U.S.C. § 902(2). Section 20(a) of the Act provides a presumption that aids the Claimant in establishing that a harm constitutes a compensable injury under the Act. Section 20(a) of the Act provides in pertinent part:

> In any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary-that the claim comes within the provisions of this Act.

33 U.S.C. § 920(a).

The Benefits Review Board (herein the Board) has explained that a claimant need not affirmatively establish a causal connection between his work and the harm he has suffered, but rather need only show that: (1) he sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which **could have caused** the harm or pain. Kelaita v. Triple A Machine Shop, 13 BRBS 326 (1981), aff'd sub nom. Kelaita v. Director, OWCP, 799 F.2d 1308 (9th Cir. 1986); Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140 (1991); Stevens v. Tacoma Boat Building Co., 23 BRBS 191 (1990). These two elements establish a **prima facie** case of a compensable "injury" supporting a claim for compensation. Id.

This statutory presumption, however, does not dispense with the requirement that a claim of injury must be made in the first instance, nor is it a substitute for the testimony necessary to establish a **prima facie** case. The U.S. Supreme Court has held that a **prima facie** claim for compensation, to which the statutory presumption refers, "must at least allege an injury that arose in the course of employment

as well as out of employment." U.S. Industries/Federal Sheet Metal, Inc. v. Director, OWCP, 455 U.S. 608, 14 BRBS 631(CRT)(1982), rev'g, Riley v. U.S. Industries/Federal Sheet Metal, Inc., 627 F.2d 455(D.C. Cir. 1980).

In U.S. Industries/Federal Sheet Metal, Inc., the claimant contended he awakened the morning of November 20th with severe pains in his neck, shoulders, and arms. Subsequently, he filed a claim under the Act alleging that he had sustained an injury during the course of his covered employment the day before. The administrative law judge discredited the claimant's testimony and the corroborating testimony of a co-worker who claimed to have witnessed the accident and found that a work-related accident never occurred on November 19th. The D.C. Circuit remanded on the basis that the "injury which occurred the morning of November 20th was entitled to the Section 20(a) presumption."

The Supreme Court reversed the D.C. Circuit by holding that the claimant had alleged an injury at work on November 19th. Since the administrative law judge had found that no work-related injury occurred on that date, there was no basis for invoking the Section 20(a) presumption for the "injury" which arose in bed. "The statutory presumption is no substitute for the allegations necessary to state a **prima facie** case." Id. at 616. Implicit in this holding is the authority of the administrative law judge to assess the credibility of each witness, including a claimant, even as to the existence of a work-related accident or injury. See also Sharp v. Marine Corps Exchange, 11 BRBS 197 (1979).

However, the Section 20(a) presumption does not assist the claimant in establishing the existence of a work-related accident or the existence of working conditions which could have caused the accident. Mock v. Newport News Shipbuilding & Dry Dock Co., 14 BRBS 275 (1981).

A claimant's **credible** subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a **prima facie** case and the invocation of the Section 20(a) presumption. See Sylvester v. Bethlehem Steel Corp., 14 BRBS 234, 236 (1981), aff'd sub nom. Sylvester v. Director, OWCP, 681 F.2d 359, 14 BRBS 984 (CRT)(5th Cir. 1982).

An administrative law judge has the discretion to determine the credibility of witnesses. Furthermore, an administrative law judge may accept a claimant's testimony as credible, despite inconsistencies, if the record provides substantial evidence of the claimant's injury. Kubin v. Pro-Football, Inc., 29 BRBS 117, 120 (1995); see also Plaquemines Equipment & Machine Co. v. Neuman, 460 F.2d 1241, 1243 (5th Cir. 1972).

Employer contends Claimant's testimony cannot be considered credible, arguing Claimant misrepresented relevant information

regarding his prior medical history, Employer/Carrier's position concerning treatment with Dr. Baker, and his move to the nightshift. Employer further contends Claimant's testimony is not credible in light of Mr. Randle's and Mr. Sutton testimony that Claimant stated he injured himself while away from the job.

With regard to his medical history, Claimant stated, in his Answers to Interrogatories, that he had seen Dr. Baker approximately seven or eight years prior to his injury for a steroid injection into his neck.[41] He provided no information regarding more recent treatment with Dr. Baker. Similarly, in his recorded statement, Claimant stated that he had not seen Dr. Baker in "years." Further, in his Interrogatory responses, Claimant also failed to identify any additional doctors who provided medical treatment for any reason prior to the instant injury. Claimant merely named Dr. Williams as his "family doctor" and referred to his prior response concerning the steroid injections performed by Dr. Baker.

Claimant's Interrogatory answers and his recorded statement are contradicted by medical reports from Dr. Baker, CRMC, and Kingwood, which indicate that Claimant sought treatment for low back pain throughout 2003 and 2004. Specifically, Claimant presented to Dr. Baker with complaints of low back pain in January, September, and December 2003 and in January, April, and May 2004. The medical reports from CRMC and Kingwood each identify complaints of low back pain in March 2003.

At formal hearing, Claimant indicated that he believed Mr. Hile asked whether he had seen Dr. Baker and he therefore responded that he had "seen this guy for years." After reviewing the transcribed recorded statement, I find Mr. Hile clearly asked Claimant when he last treated with Dr. Baker prior to the instant injury.[42] Thus, I am not persuaded by Claimant's explanation. Moreover, Claimant indicated during his recorded statement that he did not have back problems prior to June 23, 2004. Again, the medical records of evidence belie Claimant's statement.

Employer also contends the medical records contradict Claimant's hearing testimony that he did not regularly take medication for back

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[41] His answer also indicated that he had undergone previous back surgeries performed by Dr. Detenbeck.

[42] Q: Prior to this injury that we're here about, when's the last time you saw Dr. Merrimon Baker?
A: Uh, the first of July.
Q: Okay, is that because of what we're here about?
A: Yes sir.
Q: Okay. Before that? Back before this?
A: Uh, I don't remember…
Q: Years?
A: Oh, yeah it's been years.
(EX-14, pp. 9-10).

pain prior to the alleged injury. According to Dr. Baker's records, Claimant received prescriptions for pain medication in April 2004. The medications were refilled in May 2004, which I find indicates that Claimant was taking the prescription medicine on a regular basis for his back pain before the instant alleged accident. Accordingly, I find Dr. Baker's medical records contradict Claimant's testimony that he did not take prescription medication on a regular, daily basis prior to the alleged injury.

In light of the numerous dates on which Claimant sought medical attention for low back pain in the approximately one and one-half years prior to the alleged injury, which included an examination by Dr. Baker just one month before the claimed injury, I find the inconsistencies between the recorded statement, Answers to Interrogatories, and medical records weigh heavily against Claimant's credibility.

Claimant's testimony is also inconsistent with the testimony and statements provided by Mr. Randle and Mr. Sutton. With regard to working the nightshift upon his return to work for Employer, Claimant testified that he did not request a change to the nightshift and that his request to return to the dayshift had not been granted. Claimant believed he was placed on the nightshift upon his return to work as a result of filing the instant claim. However, both Mr. Randle and Mr. Sutton testified that an employee's shift is changed only upon the employee's request.

According to Mr. Randle, an employee would not be placed on the nightshift because the employee had not worked for several months or because of an on-the-job injury. Mr. Sutton was told by Claimant's foreman that Claimant requested a change in shifts from the dayshift to the nightshift. I find no reason to discount the testimony of Mr. Randle and Mr. Sutton concerning Employer's policy with respect to shift changes. Accordingly, I find that the contradictory testimony of Mr. Randle and Mr. Sutton provide further basis for diminishing Claimant's credibility.

Based on the foregoing, I find the record raises questions about Claimant's credibility that bear greatly against the weight to be afforded to his testimony when considered as a whole. In light of the inconsistencies within Claimant's own statements, as well as the contradicting medical records and conflicting testimony of other witnesses, I find Claimant is generally not credible.[43]

[43] I am not persuaded that Claimant misrepresented Employer's position regarding his treatment with Dr. Baker. Claimant's testimony indicated that he learned that he was not to continue treating with Dr. Baker during a conversation at a "deposition" at his attorney's office. He indicated that Employer's insurance adjuster did not want him to see Dr. Baker, but he could not recall whether "[Mr. Hile] said it exactly like that, or for me not to see him, or something like that." Because Claimant did not specifically state that Mr. Hile instructed him to stop treating with Dr. Baker and given

Claimant contends he sustained a new work-related injury on June 23, 2004, when his work activities aggravated and significantly worsened his pre-existing underlying back condition. Employer contends Claimant experienced consistent low back pain for one and one-half years prior to the alleged injury. It relies on Claimant's diminished credibility, as well as the statements and testimony of Mr. Randle and Mr. Sutton, as support for its contention that the claimed June 23, 2004 injury is unsubstantiated.

Claimant testified that he did not injure his back while at home during the month or week prior to June 23, 2004 and that he did not tell anyone that he injured himself away from the workplace during the week of June 23, 2004. Mr. Randle and Mr. Sutton testified otherwise. According to Mr. Randle's testimony and signed statement, Claimant stated that he hurt himself while at home. According to Mr. Sutton's testimony, Claimant stated that he "twisted or turned wrong" on the night of June 23, 2004.

It is noted that Mr. Randle and Mr. Sutton could not pinpoint the exact date of their conversation with Claimant. Mr. Randle further could not recall whether the date change on his statement had been made before or after he signed the typed statement. Nevertheless, he verified the content of his written statement and verified that the conversation occurred prior to Claimant's alleged injury.

I find no reason to question the veracity of Mr. Randle and Mr. Sutton. Because I have found that Claimant is not a credible witness, I accord greater weight to the statements and testimony of Mr. Randle and Mr. Sutton.

Although Ms. Felts testified that Claimant appeared to be in pain on June 24, 2004, her testimony is based on an observation of Claimant's subjective complaints. Similarly, review of the medical records arguably shows that Claimant's doctors relied on Claimant's complaints of pain and a history provided by Claimant in arriving at their diagnoses. Because I found Claimant is not a credible witness, these opinions must be discounted since their basis originates from subjective and incredible utterances of Claimant.

The only arguably objective medical evidence of record is an x-ray of Claimant's lumbar spine dated June 25, 2004 and a lumbar MRI dated April 9, 2004. The June 25, 2004 x-ray identified "hypertrophic spurring of the lumbar vertebral bodies," while the MRI revealed "[a]ssociated moderate facet hypertrophic changes." Without explanation regarding whether the later x-ray identifies an actual change in Claimant's condition and without further medical evidence

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the clarification from Claimant's counsel that Claimant's understanding likely stemmed from a conversation between Claimant and his attorneys, I decline to consider the foregoing testimony as weighing against Claimant's credibility.

connecting the hypertrophic spurring to the alleged June 23, 2004, work-related accident, I am not inclined to find that the x-ray provides objective evidence of a work-related injury.

The proponent of a rule or position has the burden of proof, by preponderance of the evidence, in cases resolved under the Administrative Procedures Act. See Greenwich Collieries, supra; Santoro v. Maher Terminals, Inc., 30 BRBS 171 (1996). In the instant case, the record is balanced at best. Because I conclude that Claimant has not established by a preponderance of the record evidence that he sustained a work-related injury Claimant has not met his burden of proof under the Act.

In view of the inconsistencies and contradictions evident in Claimant's own testimony, as well the inconsistencies between Claimant's testimony and that of other credible witnesses, and considering the pertinent medical evidence of record, I find and conclude Claimant failed to demonstrate he suffered a work-related accident resulting in an injury to his lower back on June 23, 2004, and thus has not established a **prima facie** case that he is entitled to the Section 20(a) presumption under the Act. See Bolden v. G.A.T.X. Terminals Corp., 30 BRBS 71 (1996).

Furthermore, since Claimant's claim is barred under the Act by his failure to demonstrate the requisite causation, the remaining issues of nature and extent, maximum medical improvement, medical care, and average weekly wage are rendered moot.

B. Section 48(a)

Section 48(a) of the Act prohibits discrimination by an employer (or his agent) against a claimant in retaliation for that claimant filing, or attempting to file, a compensation claim, or for testifying in a proceeding under the Act. Discharging or refusing to hire a person who has filed a fraudulent compensation claim is exempt from this prohibition. See 33 U.S.C. § 948(a).

The essence of a discrimination claim is that the person who filed the compensation claim is treated differently than other similarly-situated individuals. Holliman v. Newport News Shipbuilding & Dry Dock Co., 852 F.2d 759, 761, 21 BRBS 124 (CRT)(4th Cir. 1988)(all employees were required to call employer if absent for five workdays, regardless of the nature of the absence).

The Board has explained that the manner in which the claimant is treated in relation to the employer's employment practices is a factor to be considered in a Section 48(a) case. Williams v. Newport News Shipbuilding & Dry Dock Co., 14 BRBS 300, 303 (1981)(claimant was terminated for allegedly violating employer's policy against falsifying company records); Wallace v. C&P Tel. Co., 11 BRBS 826, 829 (1980). See also Powell v. Nacirema Operating Co., Inc., 19 BRBS 124 (1986).

Another factor that is relevant to the consideration of a retaliatory discharge is witness credibility. Williams, supra; Dill v. Sun Shipbuilding & Dry Dock Co., 6 BRBS 738, 743 (1978)(employer's stated reasons for termination were mere pretext for its actual reason of termination, which was to avoid future compensation liability).

1. Procedure for Raising a Section 48(a) Issue

Twenty C.F.R. §702.271(b) states:

> When a district director receives a complaint from an employee alleging discrimination as defined under section 49, he or she shall notify the employer, and within five working days, initiate specific inquiry to determine all the facts and circumstances pertaining thereto. . . .

Employer contends that the regulations require the district director to first consider the issue of a Section 48(a) violation before referring the matter to the OALJ. However, I find that the regulations do not mandate such procedure because the language used in the regulations does not set forth that the issue "shall" be raised before the district director to be a viable claim. Further, 20 C.F.R. §702.336 allows the administrative law judge to expand the hearing to include consideration of a new issue.

Employer elicited testimony concerning Employer's policy for changing a worker's schedule from the dayshift to the nightshift. Additionally, Employer was given the opportunity to cross-examine Claimant regarding his testimony that his shift change was in retaliation for filing this claim. Moreover, Employer was granted the opportunity to respond to Claimant's allegation of a Section 48(a) violation in its Response to Claimant's Post-Hearing Brief.

Although Claimant did not formally raise the issue of a Section 48(a) violation prior to or during formal hearing, I find Employer has had the opportunity to address the allegation of a Section 48(a) violation and will consider the issue.

2. The Prima Facie Case

The ultimate burden of persuasion lies with the claimant in a Section 48(a) case. Manship v. Norfolk & Western Ry. Co., 30 BRBS 175(1996); Martin v. General Dynamics Corp., Elec. Boat Div., 9 BRBS 836, 838 (1978).

In establishing a **prima facie** case under Section 48(a) of the Act, the claimant must prove that:

(1) the employer committed a discriminatory act, and

(2) the discriminatory act was motivated by **animus** against the claimant because of the claimant's pursuit of his rights under the Act.

See e.g., Holliman, 852 F.2d at 761; Geddes v. Benefits Review Bd. U.S. Dept. of Labor, 735 F.2d 1412, 1415 (D.C. Cir. 1984); Rayner v. Maritime Terminals, Inc., 22 BRBS 5, 7 (1988)(claimant's name was removed from the list of rotating crane operators, thus resulting in an economic disability); Jaros v. National Steel Shipbuilding & Dry Dock Co., 21 BRBS 26, 29-30 (1988).

The second prong of the test may be satisfied in a mixed motive situation, i.e., where the discriminatory **animus** played some part in the discriminatory act. Norfolk Shipbuilding & Drydock Corp. v. Nance, 858 F.2d 182, 187, 21 BRBS 166 (CRT)(4th Cir. 1988), cert. denied, 492 U.S. 911 (1989)(employer demonstrated general animus against longshore claimants by requiring them to resign in consideration of reaching a Section 8(i) settlement); Geddes, 735 F.2d at 1415 ("[A]n employer who discriminates against an employee both because the employee filed a compensation claim and because of other, independent reasons nonetheless violates [S]ection 49"); Curling v. Newport News Shipbuilding & Dry Dock Co., 8 BRBS 770, 772 (1978)(claimant was discharged after he failed to appear for a scheduled appointment at employer's infirmary); Dill, 6 BRBS at 743 ("[S]upervisor relied at least in part on an impermissible discriminatory reason for dismissing the claimant.").

The ALJ may infer animus from circumstances demonstrated by the record. See Brooks v. Newport News Shipbuilding & Dry Dock Co., 26 BRBS 1, 3 (1992), aff'd at 27 BRBS 100 (CRT)(4th Cir. 1993). The essence of discrimination is in treating the claimant differently from other employees. Jaros, supra.

I find that withholding Claimant's compensation benefits does not constitute a discriminatory act. Employer has the right to challenge any employee's claim for benefits. Claimant has not shown that denial of the benefits in the present matter resulted in his being treated differently than other similarly-situated employees. Accordingly, I find and conclude Employer has not committed a discriminatory act by withholding Claimant's compensation benefits.

As previously discussed, Claimant's testimony that he did not request a change to the nightshift is directly contradicted by the testimony of Mr. Sutton and Mr. Randle. Because Claimant has been discredited, I afford greater weight to the testimony of Mr. Sutton and Mr. Randle. Because the record contains no evidence to corroborate Claimant's incredible testimony, I find and conclude Claimant has not shown by a preponderance of the evidence that Employer committed a discriminatory act by placing Claimant on the nightshift upon his return to work.

Even assuming **arguendo** that Claimant credibly testified that he did not request to be placed on the nightshift, I find the record would be balanced based on the credible testimony of Claimant and the credible testimony of Mr. Randle and Mr. Sutton. Accordingly, I would find and conclude Claimant had not met his burden of showing by a preponderance of the evidence that Employer engaged in a discriminatory act against Claimant. See Greenwich Collieries, supra; Santoro v. Maher Terminals, Inc., 30 BRBS 171 (1996).

Further, I find the record is devoid of any evidence of animus. Claimant's testimony that Employer moved him to the nightshift is the only indication of animus. I find the record devoid of any evidence or testimony to support Claimant's contention and find an absence of evidence showing that Claimant was singled out due to the filing of his claim. Moreover, I find Claimant has failed to show circumstances from which animus can be inferred. Claimant's testimony provides the only basis for a finding of animus and I decline to find the presence of animus based solely on his incredible testimony. Consequently, I find and conclude Claimant has not met his burden of establishing that his shift change was motivated by animus.

Based on the foregoing, I find and conclude Claimant has not presented a **prima facie** case to establish that Employer violated Section 48(a) of the Act by placing Claimant on the nightshift upon his return to work after filing the instant claim.

V. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon considering the totality of the entire record,

IT IS HEREBY ORDERED that Claimant's claim for benefits under the Act be **DENIED.**

IT IS FURTHER ORDERED that Claimant's claim of a Section 48(a) violation be **DENIED.**

ORDERED this 31st day of March, 2006, at Covington, Louisiana.

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LEE J. ROMERO, JR.
Administrative Law Judge